Please submit forms to:

ARC Administrators
PO Box 12290
Lexington, KY 40582

Email: fsa@arcsvs.com
Fax: 859.243.0381
Toll Free: 877.309.2955

Claim Form – Flexible Spending Account and Dependent Care Account

Use this form to submit for reimbursement of eligible expenses.

Employee Name ____________________ SS# or Member ID ____________ Birth Date ____________

Email Address ____________________ Phone ____________ Group/Employer ____________

Instructions:
Please attach copies of insurance Explanation of Benefits (EOB) or itemized bill/invoice, which includes the following information:

- the date(s) of service
- the name and address of the provider who provided the service
- the amount of the charges

Service Dates	Service Provider	Claimant	Description	Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$

Claim Total $ ________

"I certify that all items claimed herein comply with the Flexible Spending Account/Dependent Care Account program, and said items have not and will not be covered by any other plan or program of any employer, or other party, and will not be reimbursed through a rebate program."

Employee Signature (required) ____________________ **Date** ____________